HOUSE BILL No. 1697

DIGEST OF INTRODUCED BILL

Citations Affected: IC 16-18-2; IC 16-21; IC 25-22.5-11.

Synopsis: Physician ownership of entities. Requires the state health commissioner to designate a hospital as a specialty hospital or a non-specialty hospital upon issuance or renewal of a hospital's license. Specifies the procedure a hospital is to follow to change the hospital's designation. Requires ambulatory outpatient surgical centers to report specified information to the state department of health. Requires the state department of health to publish an annual consumer guide to ambulatory outpatient surgical centers. Prohibits a physician with an ownership interest in a specialty hospital or an ambulatory outpatient surgical center from making certain patient referrals to the hospital or center.

Effective: July 1, 2003.

Crawford

January 21, 2003, read first time and referred to Committee on Commerce and Economic Development.

Introduced

First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

HOUSE BILL No. 1697

A BILL FOR AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16-18-2-52.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 52.5. (a) "Charity care", for purposes of IC 16-21-6 and IC 16-21-9, means the unreimbursed cost to a hospital **or an ambulatory outpatient surgical center** of providing, funding, or otherwise financially supporting health care services:

(1) to a person classified by the hospital **or the ambulatory outpatient surgical center** as financially indigent or medically indigent on an inpatient or outpatient basis; and

(2) to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

(b) As used in this section, "financially indigent" means an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on:

(1) the hospital's; **or**

(2) the ambulatory outpatient surgical center's;

financial criteria and procedure used to determine if a patient is eligible for charity care. The criteria and procedure must include income levels and means testing indexed to the federal poverty guidelines. A hospital **or an ambulatory outpatient surgical center** may determine that a person is financially or medically indigent under the hospital's eligibility system after health care services are provided.

(c) As used in this section, "medically indigent" means a person whose medical, ~~or~~ hospital, **or ambulatory outpatient surgical center** bills after payment by third party payors exceed a specified percentage of the patient's annual gross income as determined in accordance with the ~~hospital's~~ **facility's** eligibility system, and who is financially unable to pay the remaining bill.

SECTION 2. IC 16-18-2-64.4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 64.4. "Community", for purposes of IC 16-21-6 and IC 16-21-9, means the primary geographic area encompassing at least the entire county in which the hospital **or the ambulatory outpatient surgical center** is located and patient categories for which the hospital **or the ambulatory outpatient surgical center** provides health care services.

SECTION 3. IC 16-18-2-69.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 69.5. "Contributions", for purposes of IC 16-21-6 and IC 16-21-9, means the dollar value of cash donations and the fair market value at the time of donation of in kind donations to the hospital **or the ambulatory outpatient surgical center** from individuals, organizations, or other entities. The term does not include the value of a donation designated or otherwise restricted by the donor for purposes other than charity care.

SECTION 4. IC 16-18-2-335.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: **Sec. 335.5. "Specialty hospital", for purposes of IC 16-21-2, has the meaning set forth in IC 16-21-2-13.5(a).**

SECTION 5. IC 16-18-2-342.4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 342.4. (a) "Subsidized health services", for purposes of IC 16-21-6 and IC 16-21-9, means services that:

(1) are provided by a hospital **or an ambulatory outpatient surgical center,** in response to community needs, for which the reimbursement is less than the ~~hospital's~~ **facility's** cost for providing the services; and

(2) must be subsidized by other hospital **revenue sources, other ambulatory outpatient surgical center revenue sources,** or

nonprofit supporting entity revenue sources.

(b) Subsidized health services may include:

(1) emergency and trauma care;

(2) neonatal intensive care;

(3) free standing community clinics; ~~and~~

(4) collaborative efforts with local government or private agencies in preventive medicine, such as immunization programs; **and**

(5) collaborative efforts with local government or private agencies involving care or treatment available from an ambulatory outpatient surgical center.

(c) As used in this section, "nonprofit supporting entity" means a nonprofit entity that is created by the hospital or the hospital's parent entity to further the charitable purposes of the hospital and that is owned or controlled by the hospital or the hospital's parent entity.

SECTION 6. IC 16-18-2-361.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 361.5. (a) "Unreimbursed costs", for purposes of IC 16-21-6 and IC 16-21-9, means the costs a hospital **or an ambulatory outpatient surgical center** incurs for providing services after subtracting payments received from any source for such services, including the following:

(1) Third party insurance payments.

(2) Medicare payments.

(3) Medicaid payments.

(4) Medicare education reimbursements.

(5) State reimbursements for education.

(6) Payments from drug companies to pursue research.

(7) Grant funds for research.

(8) Disproportionate share payments.

(b) For purposes of this definition **as it applies to hospitals,** costs must be calculated by applying the aggregate cost to charge ratios for all hospital services derived from the hospital's Medicare cost report to billed charges. Before January 1, 1997, for purposes of this definition, charitable contributions and grants to a hospital, including transfers from endowment or other funds controlled by the hospital or the hospital's nonprofit supporting entities, shall not be subtracted from the costs of providing services for purposes of determining unreimbursed costs. Beginning January 1, 1997, for purposes of this definition, charitable contributions and grants to a hospital, including transfers from endowment or other funds controlled by the hospital or the hospital's nonprofit supporting entities, shall not be subtracted from the costs of providing services for purposes of determining the unreimbursed costs of charity care and government sponsored indigent

health care.

(c) As used in this section, "government sponsored indigent health care" has the meaning set forth in IC 16-21-9-2.

(d) As used in this section, "nonprofit supporting entity" means a nonprofit entity that is created by the hospital or the hospital's parent entity to further the charitable purposes of the hospital and that is owned or controlled by the hospital or the hospital's parent entity.

SECTION 7. IC 16-21-2-11, AS AMENDED BY P.L.162-1999, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 11. (a) An applicant must submit an application for a license on a form prepared by the state department showing that:

(1) the applicant is of reputable and responsible character;

(2) the applicant is able to comply with the minimum standards for a hospital or an ambulatory outpatient surgical center and with rules adopted under this chapter; and

(3) the applicant has complied with section 15.4 of this chapter.

(b) The application must contain the following additional information:

(1) The name of the applicant.

(2) The type of institution to be operated.

(3) The location of the institution.

(4) The name of the person to be in charge of the institution.

(5) If the applicant is a hospital, the range and types of services to be provided under the general hospital license, including any service that would otherwise require licensure by the state department under the authority of IC 16-19.

(6) Other information the state department requires, **including information necessary to determine whether a hospital should be designated as a specialty hospital or as a non-specialty hospital under section 13.5 of this chapter.**

SECTION 8. IC 16-21-2-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: **Sec. 13.5. (a) As used in this chapter, "specialty hospital" means any hospital that is licensed under this chapter and that regularly makes available either:**

(1) a range of medical services generally offered by hospitals licensed under this chapter that are non-specialty hospitals, but restricted to a defined age or gender group of the population; or

(2) a restricted range of medical services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses, injuries, or

disorders.

(b) Upon the issuance and renewal of a hospital's license under this chapter, the state health commissioner shall designate the hospital as a specialty hospital or a non-specialty hospital in accordance with subsections (d) and (e). The state health commissioner's designation under this section is subject to the review process available under IC 16-21-4.

(c) The state health commissioner:

(1) shall conduct an investigation; and

(2) may request, receive, and review information and materials from the hospital and the hospital's medical staff;

in determining whether a hospital should be designated as either a specialty hospital or a non-specialty hospital.

(d) If the state health commissioner determines that the hospital satisfies the definition of a specialty hospital under subsection (a), the state health commissioner shall designate the hospital as a specialty hospital.

(e) If the state health commissioner determines that the hospital does not satisfy the definition of a specialty hospital under subsection (a), the state health commissioner shall designate the hospital as a non-specialty hospital.

(f) A hospital's designation under this section is controlling for purposes of IC 25-22.5-11-1 until the hospital renews the hospital's license under this chapter and the state health commissioner makes a designation under this section for the hospital's license renewal. Except as provided in subsection (h), a change by the hospital that would affect the hospital's designation after the state health commissioner has made a designation under this section but before the hospital's license renewal may not be considered by the state health commissioner until the hospital renews the hospital's license under this chapter.

(g) Except as provided in subsection (h), a hospital designated as a non-specialty hospital under subsection (e) may not restrict the range or nature of the hospital's medical services in a manner that satisfies the definition of a specialty hospital in subsection (a) during the period of time after the hospital's designation but before the hospital must renew the hospital's license under this chapter.

(h) A hospital designated as a non-specialty hospital may restrict the range or nature of the hospital's medical services in a manner that results in the hospital satisfying the definition of a specialty hospital under subsection (a) before the renewal of the hospital's license under this chapter if, before restricting the range

or nature of the hospital's medical services, the following occurs:

(1) The hospital certifies to the state health commissioner the restrictions in the range or nature of the hospital's medical services that the hospital plans to implement.

(2) The state health commissioner, based on an investigation and the hospital's certification under subdivision (1):

(A) determines that the hospital will satisfy the definition of a specialty hospital under subsection (a); and

(B) designates the hospital as a specialty hospital.

(i) If a hospital restricts the range or nature of the hospital's medical services in a manner that satisfies the definition of a specialty hospital under subsection (a) without following the procedure established in subsection (h), the state health commissioner may take any of the following actions against the hospital:

(1) Deny the renewal of the hospital's license.

(2) Revoke the hospital's license.

(3) Suspend the hospital's license.

(4) Impose a civil penalty against the hospital not to exceed ten thousand dollars ($10,000).

(j) The state department may adopt rules under IC 4-22-2 necessary to carry out the purposes of this section.

SECTION 9. IC 16-21-6-0.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 0.2. As used in this chapter, "education related costs" means the unreimbursed cost to a hospital **or an ambulatory outpatient surgical center** of providing, funding, or otherwise financially supporting educational benefits, services, and programs, including:

(1) education of physicians, nurses, technicians, and other medical professionals and health care providers;

(2) provision of scholarships and funding to medical schools, colleges, and universities for health professions education;

(3) education of patients concerning diseases and home care in response to community needs; and

(4) community health education through informational programs, publications, and outreach activities in response to community needs.

SECTION 10. IC 16-21-6-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: **Sec. 3.5. (a) Each ambulatory outpatient surgical center described in IC 16-18-2-14 and licensed under IC 16-21-2 shall file with the state department a report for**

the preceding fiscal year within one hundred twenty (120) days after the end of the ambulatory outpatient surgical center's fiscal year. The state department shall grant an extension of the time to file the report if the ambulatory outpatient surgical center shows good cause for the extension. The report must contain the following:

(1) A copy of the ambulatory outpatient surgical center's balance sheet, including a statement describing the center's total assets and total liabilities.

(2) A copy of the ambulatory outpatient surgical center's income statement.

(3) A statement of changes in financial position.

(4) A statement of changes in fund balance.

(5) Accountant notes pertaining to the report.

(6) A copy of any utilization and financial reports required to be filed by the ambulatory outpatient surgical center under federal statutory law.

(7) Net patient revenue.

(8) A statement including:

(A) Medicare gross revenue;

(B) Medicaid gross revenue;

(C) other revenue from state programs;

(D) revenue from local government programs;

(E) local tax support;

(F) charitable contributions;

(G) other third party payments;

(H) gross inpatient revenue;

(I) gross outpatient revenue;

(J) contractual allowance;

(K) any other deductions from revenue;

(L) charity care provided;

(M) itemization of bad debt expense; and

(N) an estimation of the unreimbursed cost of subsidized health services.

(9) A statement itemizing donations.

(10) A statement describing the total cost of reimbursed and unreimbursed research.

(11) A statement describing the total cost of reimbursed and unreimbursed education separated into the following categories:

(A) Education of physicians, nurses, technicians, and other medical professionals and health care providers.

(B) Scholarships and funding to medical schools, colleges, and universities for health professions education.

(C) Education of patients concerning diseases and home care in response to community needs.

(D) Community health education through informal programs, publications, and outreach activities in response to community needs.

(E) Other educational services resulting in education related costs.

(b) The information in the report filed under subsection (a) must be provided from reports or audits certified by an independent certified public accountant.

SECTION 11. IC 16-21-6-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 5. If further fiscal information is necessary to verify the accuracy of any information contained in the reports filed under section 3 **or 3.5** of this chapter, the state department may require the facility to produce the records necessary to verify that information.

SECTION 12. IC 16-21-6-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: **Sec. 6.5. In addition to the report filed under section 3.5 of this chapter, each ambulatory outpatient surgical center described in IC 16-18-2-14 shall, not more than one hundred twenty (120) days after the end of each calendar quarter, file with the state department, or the state department's designated contractor, outpatient discharge information at the patient level, in a format prescribed by the state health commissioner, including the following:**

(1) The patient's:

(A) diagnoses and surgical procedures performed during the patient's stay;

(B) date of:

(i) admission;

(ii) discharge; and

(iii) birth;

(C) type of admission;

(D) admission source;

(E) gender;

(F) race;

(G) discharge disposition; and

(H) payor, including:

(i) Medicare;

(ii) Medicaid;

(iii) a local government program;

(iv) commercial insurance;

(v) self-pay; and

(vi) charity care.

(2) The total charge for the patient's stay.

(3) The United States postal code of the patient's residence.

SECTION 13. IC 16-21-6-7, AS AMENDED BY P.L.44-2002, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 7. (a) The reports filed under section 3 **or 3.5** of this chapter:

(1) may not contain information that personally identifies a patient or a consumer of health services; and

(2) must be open to public inspection.

(b) The state department shall provide copies of the reports filed under section 3 **or 3.5** of this chapter to the public upon request, at the state department's actual cost.

(c) The following apply to information that is filed under section 6 **or 6.5** of this chapter:

(1) Information filed with the state department's designated contractor:

(A) is confidential; and

(B) must be transferred by the contractor to the state department in a format determined by the state department.

(2) Information filed with the state department or transferred to the state department by the state department's designated contractor is not confidential, except that information that:

(A) personally identifies; or

(B) may be used to personally identify;

a patient or consumer may not be disclosed.

(d) An analysis completed by the state department of information that is filed under section 6 of this chapter:

(1) may not contain information that personally identifies or may be used to personally identify a patient or consumer of health services, unless the information is determined by the state department to be necessary for a public health activity;

(2) must be open to public inspection; and

(3) must be provided to the public by the state department upon request at the state department's actual cost.

SECTION 14. IC 16-21-6-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 9. (a) The state department shall adopt rules under IC 4-22-2 necessary to carry out this

chapter.

(b) The rules adopted under this section must include rules that establish a uniform system for completing the reports required under sections 3, ~~and~~ **3.5,** 6, **and 6.5** of this chapter.

(c) The rules adopted under this section must provide that, to the greatest extent possible, copies of reports required to be filed with federal, state, and local agencies may be used by facilities in completing the reports required by this chapter.

SECTION 15. IC 16-21-6-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 10. Each year the state health commissioner or the commissioner's designee shall make a compilation of the data obtained from the reports required under sections 3, ~~and~~ **3.5,** 6, **and 6.5** of this chapter and report the findings and recommendations to the general assembly not later than December 1 of the year the reports are filed. However, the commissioner is not required to incorporate a report that is required to be filed by a hospital with the state department less than one hundred twenty (120) days before December 1, but shall incorporate the report data in the report to be made the following year.

SECTION 16. IC 16-21-6-11 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 11. (a) The state department shall annually publish a consumer guide to Indiana:

(1) hospitals; **and**

(2) ambulatory outpatient surgical centers.

The state department shall compile the data for the consumer guide from the relevant data required to be filed under sections 3, ~~and~~ **3.5,** 6, **and 6.5** of this chapter and publish the data in an understandable format that assists the consuming public in making both financial and utilization comparisons between hospitals **and financial and utilization comparisons between ambulatory outpatient surgical centers.**

(b) The state department shall, upon request, provide to the public, at the state department's actual cost, copies of the consumer guide to Indiana hospitals **or copies of the consumer guide to Indiana ambulatory outpatient surgical centers** published under subsection (a).

SECTION 17. IC 25-22.5-11 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]:

Chapter 11. Physician Ownership in Health Care Entities

Sec. 1. As used in this chapter, "entity" means:

(1) a hospital licensed under IC 16-21-2 that is designated a

specialty hospital under IC 16-21-2-13.5; or

(2) an ambulatory outpatient surgical center that is licensed under IC 16-21-2 and described in IC 16-18-2-14.

Sec. 2. (a) As used in this chapter, "furnishing of health care services by an entity" means the provision of health care services by a specialty hospital (as defined in IC 16-21-2-13.5(a)) or an ambulatory outpatient surgical center (as defined in IC 16-18-2-14). Except as provided in subsection (b), the term includes any health care service claimed or billed by an entity.

(b) This term does not include the following:

(1) A health care service personally performed or provided by the referring physician that satisfies the professional component of inpatient hospital services or outpatient hospital services of health care services provided by an entity that consists of both a professional component and a technical component determined by federal Medicare reimbursement policies. A health care service is not personally performed by a referring physician if the referring physician's employee, independent contractor, or group practice member performs the service.

(2) A physician service that is personally performed or provided by the referring physician that is claimed or billed by an entity under assignment or reassignment from the referring physician.

Sec. 3. As used in this chapter, "governmental health care program" means a program that provides health care benefits that is provided by:

(1) the federal government;

(2) the state government; or

(3) a political subdivision of the state.

This term includes the federal Medicare program (42 U.S.C. 1395 et seq.), the state Medicaid program (IC 12-15), and the children's health insurance program (IC 12-17.6).

Sec. 4. As used in this chapter, "group practice" means an organization of physicians that satisfies the definition of a group practice under 42 CFR 411.352, as amended.

Sec. 5. As used in this chapter, "health care services" means health care related services or products rendered or sold by an entity within the scope of the entity's license or legal authorization.

Sec 6. As used in this chapter, "immediate family member" means the following:

(1) Spouse.

(2) Birth or adoptive:
(A) parent;
(B) child; or
(C) sibling.
(3) Stepparent.
(4) Stepchild.
(5) Stepbrother or stepsister.
(6) Father-in-law or mother-in-law.
(7) Son-in-law or daughter-in-law.
(8) Brother-in-law or sister-in-law.
(9) Grandparent or spouse of a grandparent.
(10) Grandchild or spouse of a grandchild.

Sec. 7. As used in this chapter, "inpatient hospital services" means services as defined by the federal Medicare program (42 CFR 411.351, as amended).

Sec. 8. As used in this chapter, "outpatient hospital services" means services as defined by the federal Medicare program (42 CFR 411.351, as amended).

Sec. 9. As used in this chapter, "ownership interest with an entity" means an ownership interest through equity, debt, or other means. This term includes an interest in an entity that holds an ownership or investment interest in the entity.

Sec. 10. As used in this chapter, "physician services" has the meaning set forth in 42 U.S.C. 1395x(q), as amended.

Sec. 11. As used in this chapter, "referral" means:
(1) a physician forwarding a patient to an entity for one (1) or more health care services furnished by the entity;
(2) a physician forwarding a patient to a health care provider for one (1) or more health care services furnished by the health care provider; or
(3) a physician's request or establishment of a plan of care for health care services to be furnished by an entity.

Sec. 12. (a) Except as provided in subsection (b), if a physician licensed under this article or a member of the physician's immediate family has an ownership interest in an entity, the physician may not refer a patient to the entity for the furnishing of health care services.

(b) This section and section 13 of this chapter do not apply to the following:
(1) An ownership interest that is vested before July 1, 2003, with an ambulatory outpatient surgical center that is licensed under IC 16-21-2 before July 1, 2003.

(2) An ownership interest that is vested before July 1, 2003, with a hospital that is licensed under IC 16-21-2 before July 1, 2003, regardless of whether the hospital is designated as a specialty hospital after June 30, 2003, under IC 16-21-2-13.5.

(3) Ownership or investment securities, including shares or bonds, debentures, notes, or other debt instruments, that may be purchased on terms generally available to the public and that are:

(A) securities:

(i) listed on the New York Stock Exchange, the American Stock Exchange, or any regional exchange in which quotations are published on a daily basis; or

(ii) traded under an automated interdealer quotation system operated by the National Association of Securities Dealers;

(B) foreign securities listed on a recognized foreign, national, or regional exchange in which quotations are published on a daily basis; or

(C) in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous three (3) fiscal years, stockholder equity of at least seventy-five million dollars ($75,000,000).

(4) Ownership of shares in a regulated investment company as defined in section 851(a) of the Internal Revenue Code of 1986, if the company had, at the end of the company's most recent fiscal year, or on an average during the previous three (3) fiscal years, total assets of at least seventy-five million dollars ($75,000,000).

(c) Subsection (a) and section 13 of this chapter apply to the following:

(1) An ownership interest that vests after June 30, 2003, with a hospital if, and for as long as, the hospital is designated as a specialty hospital under IC 16-21-2-13.5.

(2) An ownership interest that vests before July 1, 2003, with a hospital that is not issued a license under IC 16-21-2 until after June 30, 2003, if, and for as long as, the hospital is designated as a specialty hospital under IC 16-21-2-13.5.

(3) An ownership interest that vests after June 30, 2003, with an ambulatory outpatient surgical center.

(4) An ownership interest that vests before July 1, 2003, with an ambulatory outpatient surgical center that is not issued a license under IC 16-21-2 until after July 1, 2003.

(d) The furnishing of health care services by an entity does not include physician services that are personally performed or provided by the referring physician and that are claimed or billed as physician services independently of an entity's health care services. A physician service is not personally performed or provided by the referring physician if the service is performed or provided by any other person, including the referring physician's:

(1) employees;

(2) contractors; or

(3) group practice members.

(e) A physician service that is personally performed or provided by the referring physician may not be considered a service furnished by an entity when the physician service is claimed or billed by an entity under assignment or reassignment from the referring physician.

(f) The furnishing of service or items by an entity includes an entity's health care services that are inpatient hospital services or outpatient hospital services.

(g) The furnishing of health care services by an entity does not include any service personally performed or provided by the referring physician in satisfaction of the professional component of health care services that is an inpatient hospital service or outpatient hospital service and that is furnished by the entity if the health care services include both a technical and professional component determined by federal Medicare program reimbursement policies and principles.

(h) A service is not personally performed or provided by the referring physician if the service is performed or provided by any other person, including the referring physician's:

(1) employees;

(2) independent contractors; or

(3) group practice members.

Sec. 13. An entity that provides health care services to a patient whose referral is prohibited by section 12 of this chapter may not present or cause to be presented a claim or bill to any individual, third-party payor, governmental health care program, or other person for the health care services provided in the prohibited referral.

Sec. 14. The furnishing of health care services by an entity includes any health care service claimed or billed by an entity except for:

(1) a physician service that is personally performed or

provided by the referring physician that is claimed or billed by an entity under assignment or reassignment from the referring physician as described in section 12(e) of this chapter; and

(2) a health care service personally performed or provided by a referring physician in satisfaction of the professional component of a service or item as described in section 12(g) of this chapter.

Sec. 15. (a) A claim or bill of payment may not be presented to any individual, third-party payor, governmental health care program, or other person for a health care service furnished by an entity under a referral prohibited by section 12 of this chapter.

(b) If a physician, an entity, or any other person collects any amount that was claimed or billed in violation of subsection (a), the physician, entity, or other person shall refund the amount to the individual, payor, program, or other person not later than thirty (30) days after the earlier of the physician, entity, or other person:

(1) receiving a written request for a refund; or

(2) discovering that the claim or bill violates subsection (a).

Sec. 16. (a) A physician, an entity, or other person that presents or causes to be presented a bill or a claim for a service that the physician, entity, or person knows or should know is for a service for which the payment violates section 15 of this chapter or for which a refund has not been made under section 15 of this chapter is subject to a civil penalty of not more than fifteen thousand dollars ($15,000) for each service.

(b) The civil penalty under subsection (a) shall be imposed and collected against:

(1) an entity by the state department of health; and

(2) a person other than an entity by the medical licensing board.

(c) A physician who knowingly violates a prohibition set forth in this chapter commits an act subject to disciplinary action by the medical licensing board under IC 25-1-9-4(a)(3) and IC 25-1-9-9.

(d) An entity that violates this chapter has committed an act subject to disciplinary action by the state department of health under IC 16-21.

SECTION 18. [EFFECTIVE JULY 1, 2003] **(a) A hospital licensed under IC 16-21-2 before July 1, 2003, may not be considered a specialty hospital or a non-specialty hospital under IC 16-21-2-13.5, as added by this act, or IC 25-22.5-11, as added by this act, until the hospital renews its license under IC 16-21-2 and**

the state health commissioner designates the hospital as a specialty hospital or a non-specialty hospital under IC 16-21-2-13.5, as added by this act.

(b) This SECTION expires December 31, 2008.